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Anterior Vaginal Repair - Patient Information

Repair of anterior vaginal prolapse ("cystocoele" or bulging of the bladder into the vagina) in order to relieve symptoms of a vaginal lump and urinary urgency/frequency.

Surgical technique

- The procedure can be performed under general or regional anaesthesia
- The vagina overlying the bladder and urethra is incised in the midline and the supporting fascia is exposed and plicated (stitched together) in the midline using absorbable sutures
- Sometimes excessive vaginal skin is removed and the vaginal skin is closed with absorbable sutures
- Occasionally reinforcement material in the form of mesh or biological material is used in cases of repeat surgery or severe prolapse
- A cystoscopy is performed to confirm normal bladder and ureteric function
- Surgery will be covered with antibiotics to decrease the risk of infection and blood thinning agents will be used to decrease the risk of clots forming in the postoperative phase.
- A vaginal pack and catheter, if used, are usually removed the morning after surgery or after 48 hours.

Complications

- 15-30% of women will develop recurrent bladder prolapse
- 5-10% after a large bladder prolapse is repaired may develop stress urinary leakage that was not present before the surgery (occult or masked stress incontinence)
- 1-2% have difficulty passing urine requiring prolonged catheter usage and the need to learn clean intermittent self catheterisation.
- Inadvertent damage to the urethra or bladder occurs rarely (3/1000) and is usually repaired during the surgery. If the damage is not repaired at the time of the surgery a fistula between the bladder and vagina can occur (1-2/1000 cases)
- 1-5% develop a urinary tract infection
- Excessive bleeding is rare, if unable to be controlled may require return to surgery
- Clots can form in the legs or lungs after any pelvic surgery <1%
- Surgical repair of cystocoele alone is unlikely to adversely affect sexual function and often has a positive effect on sexual function due to relief of symptoms
- If mesh is used for reinforcement there is a 5-10% risk of mesh erosion requiring trimming as an office procedure or a brief return to theatre

In hospital and recovery
You can expect to stay in hospital between 2-4 days. Bleeding may continue for up to 10 days and discharge for 6 weeks whilst sutures are dissolving.

In the early postoperative period you should avoid situations where excessive pressure is placed on the repair, i.e. lifting, constipation, etc. Maximal fibrosis around the repair occurs at 3 months and care with heavy lifting >5 kg needs to be taken until this time. If you develop urinary burning, frequency or urgency you should see your local doctor for a urine culture and/or antibiotics.

You will be reviewed by Dr De Souza at six weeks and sexual activity can usually be resumed at this time. You can return to work at approximately 4-6 weeks depending on the amount of strain that will be placed on the repair at your work and on how you feel.